KAISER PERMANENTE

Name: _____

MRN: _____

PRE-SURGERY QUESTIONNAIRE

Please complete prior to your Preoperative Medicine (POM) Appt.

Have you had any recent changes in your health? Yes: ☐ No: ☐

If you answered yes to the above question please describe here:

_____

_____

_____

We would like to ask if you have recently had any of the following:

	Yes	No		Yes	No
Fever:			Shortness of breath with activity:		
Chills:			Shortness of breath with laying flat:		
Dry Cough or Cough with sputum:			Shortness of breath at night:		
Generalized Weakness or numbness: Weakness or numbness limited to one part of your body			Have you had a rapid heart or chest pain in the last year: Any skin changes over your surgical site? recent rashes?		
			Neck stiffness or joint pain:		
Fatigue:			Weight Change:		
Headache:			Swelling in your ankles or legs:		
Fainting:			Burning with urination:		
Dizzy spells:			Urgency with urination:		
Seizures:			Urinating more frequently than usual:		
Easy Bruising:			Easy bleeding that can be hard to control:		

	Yes	No		Yes	No
Heartburn:			Severe motion sickness:		
History of Chronic pain:			Personal history of anesthetic complications such as malignant hyperthermia or pseudocholinesterase deficiency? Bleeding?		
Do you frequently snore loudly?			Family history of anesthetic complications such as muscular dystrophy, malignant hyperthermia, or pseudocholinesterase deficiency? Bleeding?		
Do you use CPAP Machine?					
Has anyone observed your breathing stop during sleep?			Do you have any objections to transfusion?		
Do you wake up with severe headaches frequently in the morning?					
Do you often feel tired, fatigued, or sleepy during the daytime?			For Women: Any possibility you could be pregnant?		

In the past month have you done these things? Check if Yes

☐ Walk indoors (for example around your house)?

☐ Walk a block or two on level ground?

☐ Do house hold chores or washing dishes or laundry?

☐ Do vacuuming around the house?

☐ Do yard work like raking leaves, weeding or pushing a lawn mower?

☐ Participate in moderate recreational activities like golf, bowling, dancing, double tennis, throwing a baseball or football?

☐ Participate in strenuous sports like swimming, singles tennis, football, basketball or skiing?

☐ Do heavy work around the house like scrubbing floors, lifting or moving heavy furniture?

What is your Occupation? _____

Past Medical History

Please check the following medical diseases for which you are now being treated or have been treated in the past:

☐ High blood pressure: Year it was diagnosed:_____
☐ Diabetes Year it was diagnosed:_____
If you are a Diabetic usual range of blood sugars in the morning:
_____

☐ Heart attack Year you had it:_____
☐ Angioplasty and Stent Year you had it:_____
☐ Congestive Heart Failure
☐ History of a stroke
☐ History of a blood clot in your legs or lungs?
Year you had it:_____

Date of your last Dental cleaning and check ups:_____
Were there any cavities found? Yes: ☐ No: ☐
Did the dentist feel you needed additional work? Yes: ☐ No: ☐
If yes please describe:_____

Please list your drug and other allergies (latex, iodine or shellfish) here:
Drug:_____Type of reaction:_____

Drug:_____Type of reaction:_____

Drug:_____Type of reaction:_____

How many drinks containing alcohol do you drink a day? _____
How much tobacco do you smoke a day? _____
What recreational drugs do you currently use? _____

Please be prepared to talk about the medications you take -if you do not have a list we can print one up for you. We will need to know the dose and the frequency of your medications.

In particular-we are interested if you take:
☐ Aspirin
☐ Fish oil
☐ Other supplements:

Please list your previous surgeries, the year of the surgeries, and any problems after surgery like vomiting, difficulty breathing etc. You may attach a separate sheet if needed.

Surgery	Date	Problems after surgery such as vomiting? If yes please describe

Have you ever had a difficult urinary bladder catheter (Foley) placement?

Have you ever been confused in the hospital before?
Have any medications made you confused before?

Do you have a short term memory problem?

Do you designate someone to make your health care decisions for you in the event that you can not? _____

If yes who? _____